

Duval County Health Department Public Stockpile Antiviral Transfer Procedures

The following procedures should be used to transfer of public stockpile Antivirals from the Duval County Health Department (DCHD) to local healthcare entities:

1. The healthcare entity shall request public stockpile Antivirals using the using the ***Tamifl/Relenza Requisition Form (see next page)***.
2. The healthcare entity may fax or hand-deliver the request to the DCHD PHARMACY Department.
 - a. Address: 515 West 6th Street, Jacksonville, FL 32206
 - b. Phone: (904) 253-1530
 - c. Fax: (904) 253-1955
3. DCHD personnel will fill requests within 48-hours. Product will be available for pickup from the DCHD Pharmacy Department.
4. The healthcare entity will sign for receipt of public stockpile antivirals upon pickup.
5. A copy of the receipt will be provided with each order to the healthcare entity. DCHD will retain copies of all transactions.
6. Medications provided are subject to audit for proper use in the future. Detailed records of distribution must be maintained by the healthcare entity.
7. The healthcare entity shall provide weekly reports, every Tuesday, to DCHD on the public stockpile Antivirals that have been dispensed.

Acknowledgement:

The healthcare entity acknowledges receipt of public stockpile Antivirals from the Duval County Health Department Pharmacy Department. The public stockpile Antivirals will be provided at no charge to eligible patients based on the most current CDC Recommendations.

The following persons will be the responsible party for providing weekly reports every Tuesday for public stockpile Antivirals that have been dispensed.

Name/Title: _____

E-mail Address: _____

Phone: _____

Name/Title: _____

E-mail Address: _____

Phone: _____

Attestation: I agree to adhere to the information as stated above.

Name: _____ Healthcare Entity: _____

Signature: _____ Date: _____

Duval County Health Department Public Stockpile Antivirals
*** TAMIFLU/RELENZA REQUISITION FORM ***
PLEASE PRINT ALL REQUIRED INFORMATION

Requesting/Receiving Entity:

FACILITY: _____
 ADDRESS: _____
 PHONE#: _____ FAX#: _____
 PHARMACY / PROVIDER: PERMIT/LICENSE #: _____
 DIRECTOR OR DESIGNEE (Print) _____
 (Sign) _____

County Health Department:

FACILITY: **DUVAL COUNTY HEALTH DEPARTMENT**
 ADDRESS: **515 WEST 6TH STREET JAX., FL 32218**
 PHONE#: **(904) 253-1530** FAX#: **(904) 253-1955**
 PHARMACY PERMIT/LICENSE #: **PH13640**
 STAFF FILLING REQUEST (Print) _____
 (Sign) _____

	<u>QTY REQUESTED:</u>	<u>QTY ISSUED:</u>		
TAMIFLU 75mg Capsules, Blister of 10 Capsules	_____ Cases (3 Max)	_____ Cases/_____ Regimens	Lot # _____	Exp. Date: _____
TAMIFLU 30mg Capsules, Blister of 10 Capsules	_____ Cases (3 Max)	_____ Cases/_____ Regimens	Lot # _____	Exp. Date: _____
TAMIFLU 45mg Capsules, Blister of 10 Capsules	_____ Cases (1 Max)	_____ Cases/_____ Regimens	Lot # _____	Exp. Date: _____
TAMIFLU 300mg Oral Suspension, 300mg	_____ Cases (1 Max)	_____ Cases/_____ Regimens	Lot # _____	Exp. Date: _____
RELENZA Diskhaler system 5mg	_____ Cases (1 Max)	_____ Cases/_____ Regimens	Lot # _____	Exp. Date: _____

RECEIVED BY: (Print): _____ (Sign): _____ DATE: _____

****FOR USE BY RECEIVING PERSONNEL ONLY****

	<u>QUANTITY RETURNED (Case/Regimens):</u>	<u>Lot#</u>	
TAMIFLU 75mg Capsules	_____	_____	RECEIVED BY: (Print): _____
TAMIFLU 30mg Capsules	_____	_____	(Sign): _____
TAMIFLU 45mg Capsules	_____	_____	ISSUED BY: (Print) _____
TAMIFLU 300mg Oral Suspension	_____	_____	(Sign) _____
RELENZA Diskhaler system 5mg	_____	_____	DATE: _____